IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-5747
FAX: (208) 364-1811

October 4, 2007

Jennifer Lyn Davis, Administrator
Mallory House
3400 S 5th West
Idaho Falls, ID 83402

License #: RC-534

Dear Ms. Davis:

On August 21, 2007, a complaint investigation, follow-up/revisit, state licensure survey was conducted at Mallory House. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact Karen McDannel, RN, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

Karen McDannel, RN

KAREN MCDANNEL, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

KM/sc

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FAX: (208) 364-1811

September 5, 2007

CERTIFIED MAIL #: 7003 0500 0003 1967 0643

Jennifer Lyn Davis, Administrator
Mallory House
3400 S 5th West
Idaho Falls, ID 83402

Dear Ms. Davis:

On **August 21, 2007,** a follow-up/revisit to the state licensure survey and complaint investigation of April 20, 2007 was conducted by our staff at Mallory House. As a result of the survey, core issue deficiencies were cited. Enclosed is a Statement of Deficiencies.

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **September 18, 2007,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

Due to the continued failure of the facility to correct non-core issue deficiencies, in accordance with IDAPA 16.03.22.910.02. the following enforcement actions are imposed:

1. **A consultant, with a background in residential care and either an Idaho RN license or an Idaho Residential Care Facility Administrator's license will be obtained and paid for by the facility and approved by the Department. This consultant may not also be employed by the facility as a regular employee. The consultant is to be allowed unlimited access to the facility and its systems for the provision of care to residents. The name of the consultant with the person's qualifications and a copy of their license will be submitted to the Department for approval no later than September 14, 2007;**

2. **The Department approved consultant will submit a weekly written report to the Department commencing on September 21, *2007* and every Friday thereafter. The reports will address progress on correcting the deficiencies on the Non-Core Issues Punch Lists as well as progress on correction of the core issues identified on The Statement of Deficiencies.**

3. **A provisional license is issued which is to be prominently displayed in the facility. Upon receipt of this provisional license return the full license, currently held by the facility.**

4. **When the consultant and the administrator agree the facility is in full compliance, they will submit the completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) to this office, and a follow up survey will be conducted. To avoid further enforcement actions, full compliance must be achieved on or before October 5, 2007.**

Please be advised that you may contest this decision by filing a written request for administrative review pursuant to IDAPA 16.05.03.300. **no later than twenty-eight (28) days after this notice was mailed.** Any such request should be addressed to:

Randy May
Deputy Administrator
Division of Medicaid-DHW
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

If you fail to file a request for administrative review within the time allowed, this decision shall become final.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**September 18, 2007**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **September 18, 2007,** your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the Punch List, a copy of which was reviewed and left with you during the exit conference. The completed Punch List form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **September 21, 2007**.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Community Care Program

JS/ slc
Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R534	A. BUILDING _____ B. WING _____	R 08/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALLORY HOUSE	3400 S 5TH WEST IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments The following repeat core deficiencies were cited during the Follow-up Survey conducted at your residential care/assisted living facility on 8/21/07. The surveyors conducting your survey were: Karen McDannel, RN Team Coordinator Health Facility Surveyor Rachel Corey, RN Health Facility Surveyor Donna Henscheid, LSW Health Facility Surveyor Survey Definitions: BMP = Behavior Modification Plan COPD = Chronic Obstructive Pulmonary Disease MAR = Medication Administration Record ML = Milliliter NC= Nasal Canula NSA = Negotiated Service Agreement PO = By Mouth PRN = As Needed RN = Registered Nurse	R 000		
{R 008}	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to develop an NSA to include a BMP to direct staff regarding ongoing behaviors for sampled	{R 008}		

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{R 008}	Continued From page 1 Resident #5. The facility also failed to implement an NSA to meet the residents' ADL needs for 2 of 5 sampled residents (#'s 3 & 5). Further, the facility failed to update an NSA to reflect the change in condition for 1 of 5 sampled residents Resident #2. Additionally, the facility failed to provide assistance and monitoring of medications for 2 of 5 sampled residents (#2 and #5). The findings include: I. NSAs A. DEVELOPMENT OF NSA TO INCLUDE BMP Resident #5 was admitted to the facility on 3/4/05, with diagnoses which included short-term memory loss, diabetes mellitus and kidney failure. Review of Resident #5's record revealed an NSA dated 1/20/07, which documented the resident did not "currently have any behavior issues that require monitoring." The resident's "Behavior Strategy Plan" [BSP] (undated), documented the following: "Behavioral Concern: Refusal to shower...Potential Strategy To Control Stimuli:...Staff will report any refusal of shower to RN...Staff will read, follow and chart according to BSP. Staff will report to RN...immediately if any behaviors are observed." The "Resident's Behavior Report" dated from 5/13/07 through 8/18/07, for Resident #5's refusal of showers did not include action taken by staff, but only documented the resident's refusal. The "Staff Communication Log" reviewed from 8/5/07 through 8/19/07, documented Resident #5 had no behaviors or concerns.	{R 008}		

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{R 008}	Continued From page 2 On 8/21/07 the facility's "Shower Log" was reviewed and revealed the resident had refused showers and had not had a shower in 14 days, with last shower on 8/5/07. On 8/21/07 at 9:00 a.m., the administrator and the facility nurse stated they were not aware that the resident had been refusing showers for the past 14 days. The facility did not develop an NSA to include a BMP with staff interventions for Resident #5's refusal of showers and failed to provide direction to staff in their provision of care and services to meet the needs of Resident #5. B. UPDATE NSA Resident #2 was admitted on 2/15/06 with diagnoses including the following: COPD, hypertension, chronic pain, diabetes, lower extremity edema and asthma. Resident #2's NSA dated 7/31/07 documented the resident was continent of bowel and bladder and required no assistance with toileting. On 8/20/07 at approximately 2:00 p.m., the resident's room was observed to have a very strong urine odor, several used attends were observed in the trash and the resident was observed to leave a six inch puddle of urine in the wheel chair after transferring to a recliner. On 8/20/07 at 2:10 p.m., the resident stated she had been having trouble with incontinence and frequent urinary tract infections. The resident also stated she wore nightgowns throughout the day because it was easier for her to change her	{R 008}		

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{R 008}	Continued From page 3 attends. On 8/20/07 at 2:13 p.m., a caregiver stated the resident goes to the toilet by herself and that staff "doesn't do anything with her toileting." On 8/21/07 at 11:30 a.m., the facility RN and administrator stated they were not aware of the resident's increased incontinence and confirmed she needed more assistance with toileting than what was reflected on her NSA. The facility did not update Resident #2's NSA to provide guidance to staff regarding the resident's increased need for toileting assistance. C. NSA IMPLEMENTATION 1. Resident #5 was admitted to the facility on 3/4/05, with diagnoses which included short-term memory loss, hypertension, diabetes mellitus, kidney failure. Resident #5's NSA dated 1/20/07, documented the resident was incontinent of bladder, had accidents caused by diarrhea, and would try to clean himself up without assistance. The NSA instructed staff to check for incontinent clothing, assist with pericare after finding soiled clothing to prevent skin breakdown. Review of the facility's "Resident Service Notes" dated 7/2/07, documented "Resident has been itching groin area. Upon assessment; groin is red and has foul odor. Order received for Nystatin powder to area twice a day until healed." During the survey on 8/20/07 at 2:00 p.m., the resident was observed sitting in a recliner in his room. Beside the resident was a pile of soiled	{R 008}		

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{R 008}	Continued From page 4 clothing. The room had a foul odor, and was unkempt. The toilet bowl was splattered with diarrhea, and there was a strong foul odor in the bathroom. On 8/21/07 at 7:30 a.m., the resident was observed sitting in his recliner. The pile of soiled clothing remained and the amount had increased. On 8/21/07 at 7:45 a.m., a caregiver stated the facility has not had housekeeping staff for at least one month. The caregiver confirmed staff was not able to keep up with the housekeeping duties and the resident's laundry had accumulated at times. He also confirmed the bathroom was in need of cleaning. When asked about the condition of the resident's groin, the caregiver stated, "I have not observed his groin area in over a week. The resident tries to take care of his own pericare and doesn't ask for help." On 8/21/07 at 9:00 a.m., the facility nurse stated, "I was not aware that staff were not consistently assisting the resident with pericare and thought staff had been observing the resident's groin area and would report any changes to me." 2. Resident #3 was admitted on 7/9/05, with diagnoses including: hypertension, anemia, edema, and cerebral vascular accident. Resident #3's NSA dated 8/13/07, documented the resident was incontinent of bladder requiring her to wear attends. The NSA documented staff were to assist resident with checking and changing attends throughout each shift. The NSA also documented that the resident was able to ambulate short distances with stand by assistance and was at risk for falls due to an	{R 008}		

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{R 008}	Continued From page 5 unsteady gait. On 8/20/07 at 2:10 p.m., Resident #3's room was observed to have a strong urine odor. In addition, blue incontinent pads over the resident's mattress were observed to be damp and smell of urine. At this time, the resident stated, "There is not enough people here to help me." On 8/21/07 at 9:30 a.m., resident #3's room smelled of urine. The resident was observed lying in bed stating that she had not gotten up for the day nor changed her attends since last night as she doesn't like to get up early. Resident stated that typically she ambulates to the bathroom, changes attends and preforms pericare without staff assistance. She stated that she has had frequent urinary tract infections and was unsure if the infections were related to pericare practices. On 8/21/07 at 8:30 a.m., a caregiver stated that resident #3 was independent with toileting and pericare. On 8/21/07 at 8:40 a.m., a second caregiver confirmed that resident #3 changed her own attends and performed pericare without assistance. On 8/21/07 at 10:00 a.m., the facility nurse confirmed that staff were not checking resident #3's attends, assessing her ability to change attends or performing pericare appropriately. The facility nurse stated resident was currently on antibiotic to treat a recent urinary tract infection. The facility did not implement the NSA's regarding Resident #3's & #5's toileting, pericare needs and Resident #3's assistance with ambulation.	{R 008}		

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{R 008}	Continued From page 6 II. ASSISTANCE AND MONITORING OF MEDICATIONS 1. Resident #2 was admitted on 2/15/06 with diagnoses including the following: COPD, hypertension, chronic pain, diabetes, lower extremity edema, and asthma. Resident #2's NSA dated 7/31/07 documented the resident required assistance with all medications and was not able to self-medicate. Further, the NSA documented the resident used a nebulizer and was able perform treatments herself as ordered by the physician. The NSA did not document the resident's need for oxygen. A. Resident #2's Quarterly Nursing Assessment dated 7/9/07 documented the resident was able to partially self-medicate "Rolaids and nasal spray." The nursing assessment did not include self-administering of nebulizer treatments. Resident #2's MAR dated 8/15/07 through 9/13/07 documented Duoneb U-D, dose 1 ML ampule with nebulizer 4 times daily and as needed for shortness of breath. From 8/15/07 through 8/20/07 the MAR documented that staff assisted with the nebulizer treatments only 4 times out of the 24 ordered treatments. On 8/20/07 the resident was observed to have a nebulizer machine in her room. When asked about frequency of usage, the resident responded, "I'm suppose to have them (nebulizer treatments) 3 times a day but I haven't been." On 8/21/07 at 10:00 a.m., a caregiver stated the nebulizer treatments are "PRN, only given when the resident asks."	{R 008}		

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{R 008}	Continued From page 7 On 8/21/07 at 11:00 a.m., the facility nurse stated she was not aware the nebulizer treatments were ordered as both scheduled and PRN and confirmed the resident had not been assessed to self-administer the nebulizer treatments and had not received them as ordered by the physician. B. A Quarterly Nursing Assessment dated 7/9/07 documented the resident had oxygen via nasal cannula but no liter flow was specified. On 8/20/07 the resident was observed wearing oxygen via nasal cannula. When asked about her liter flow, the resident responded, "It's suppose to be set at 4 liters." The concentrator was observed to be set at 3 liters. On 8/21/07 the facility RN stated she was not aware of the liter flow and confirmed there were no physician orders specifying the oxygen flow. On 8/21/07 at 12:42 p.m., a physician order was received and documented the following:"O2 4 L. via NC continuous." The facility failed to provide assistance with nebulizer treatments as ordered by the physicain. Additionally, the facility did not provide adequate monitoring of oxygen usage and ensure that physician orders were obtained to direct liter flow. 2. Resident #5 was admitted to the facility on 3/4/05, with diagnoses which included short-term memory loss, hypertension, diabetes mellitus, kidney failure. Resident #5's NSA dated 1/20/07, documented the resident required assistance with all medications and was not able to self-medicate.	{R 008}		

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{R 008}	Continued From page 8 Review of the physician's order dated 5/31/07, documented "Lantus 5's 100 U/1 ml. 12 units HS [at bedtime]." Resident #5's MAR dated 8/15/07 through 9/13/07, documented the resident received "Lantus 5's 100 U/1 ml cartridge inject 12 units subcutaneously at bedtime for Diabetes." The Nursing Assessment dated 6/18/07, documented the resident was not able to self medicate. The assessment did not include whether or not the resident was able to safely dial an insulin pen or inject his own insulin from a pen or a syringe. On 8/21/07 at 8:45 a.m., Resident #5 denied the use of insulin and stated "I have never been on insulin." On 8/21/07 at 8:50 a.m., the facility nurse acknowledged she had not assessed the resident's ability to safely inject insulin using a syringe. On 8/21/07 at 9:00 a.m., the facility nurse stated, "There are three residents in the facility who currently use an insulin pen." When asked by the surveyors to identify the residents using the insulin pen she confirmed, Resident #5 was using an insulin pen. She further stated, "the resident was not able to dial the dosage amount of insulin and that unlicensed staff had been dialing the dose, but she thought the resident was able to inject his own insulin." On 8/21/07 at 9:10 a.m., the unlicensed medication aide stated, "The medication aides dial the insulin pen and we have been giving the	{R 008}		

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{R 008}	Continued From page 9 insulin injections." On 8/21/07 at 4:15 p.m., the facility nurse confirmed unlicensed staff had been dialing the dose of insulin for the resident. The administrator and the nurse acknowledged that dialing a dose of insulin from the insulin pen was not a task that could be delegated. The immediate danger situation was corrected by the nurse. She pre-filled the syringes with the correct insulin dose. In addition, the nurse assessed the resident's ability to correctly self-inject using a syringe. The facility RN failed to assure Resident #2 was assisted with nebulizer treatments as ordered by the physician. Further, the facility RN did not assure Resident #2 had a physician order for oxygen nor did she assure the oxygen liter flow was consistently set as ordered. Additionally, the facility RN failed to assess Resident #5's capability to safely self-administer insulin injections. Non-licensed staff were allowed to administer insulin via an insulin pen to Resident #5, which is a nursing task that cannot be delegated. The facility was required to submit an immediate plan of correction to assure the Resident #5 could safely receive his insulin from prefilled syringes. The facility failed to develop, update and implement NSAs to identify and describe Residents #2, 3 & 5's needs. The facility failed to develop a BMP for Residents #5's inappropriate behaviors. The incomplete BMP did not provide guidance to personnel to meet the hygiene needs of Resident #5. The facility failed to provide assistance and monitoring of medications for Residents #2 & 5. Furthermore, the facility failed to protect Resident #5 from immediate danger	{R 008}		

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{R 008}	Continued From page 10 when the resident was unable to self-administer insulin and the facility allowed unlicensed staff to dial the dose of an insulin pen. These failures resulted in inadequate care as 3 of 5 sampled residents did not receive basic care services. This is a repeat core deficiency.	{R 008}		

IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
Mallory House	3400 S 5th West	208-528-6599
Administrator	**City**	**ZIP Code**
Jennifer Davis	Idaho Falls	83402
Survey Team Leader	**Survey Type**	**Survey Date**
Karen McDanne/	Follow-Up	8/21/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
1	260.06	The facility did not maintain the interior of the facility in a clean and safe manner i.e.: RM 101 door sticking; RM 115 - foul odor in room, toilet dirty; RM 113 - foul odor in room; RM 118 - bottom of door scratched and needs repainting; RM 119 - stains on toilet, crumbs + debris on floor; RM 124 - carpet stained, toilet dirty and not secured to floor and uncaulked; RM 127 - foul odor in room, toilet dirty, dirty laundry piled in front of window; RM 128 - strong urine odor, toilet, room cluttered and dirty; RM 130 - hole in wall, stained carpet in front of door outside room; RM 133 - black stains on bathroom floor; RM - 136 - food and debris on counter and carpeting; stains on carpet throughout facility, toilet paper not in holders / holders missing rollers; employee bathroom (S. Hallway) torn and blind opener broken in hallway near RM 119/120. RM 124 also has plaster coming off walls where hit with electric w/c.	10/9/07	

Response Required Date	Signature of Facility Representative	Date Signed
9/21/07	Jennifer Davis	8-21-07

IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
Mallory House	3400 S 5th West	208-528-6599
Administrator	**City**	**ZIP Code**
Jennifer Davis	Idaho Falls	83402
Survey Team Leader	**Survey Type**	**Survey Date**
Karen McDannel	Follow-up	8/21/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
2	305.06	The facility did not conduct an initial assessment for residents to self administer medications i.e.: Resident #2's self-administration of duonebs and Random Residents self-administration of insulin pen.	10/4/07 RC	

Response Required Date	Signature of Facility Representative	Date Signed
9/21/07	Jennifer Davis	8-21-07